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Thank you for this opportunity to provide testimony on the important issues presented by the Commission's follow-up work to its 2003 and 2005 reports on ensuring a high quality public health system in California.

Consumers Union is the nonprofit publisher of *Consumer Reports*. For more than 30 years, the West Coast Office of Consumers Union in San Francisco has been advocating solely on behalf of consumers in a wide range of forums—including the Legislature, administrative agencies, courts, board and commissions. Our mission is to enhance the functioning of the marketplace through information and advocacy, to promote transparency in both government and the marketplace, and to redress marketplace imbalances or malfunctions when needed through government action. The opinions I express today are informed by Consumers Union's longstanding work in health care policy and advocacy, and patient safety and quality in particular.

For the past six years, including during health reform debates of the past two years, we have worked intensively on health care "transparency," getting medical outcome information about providers out into the public realm. Research has shown that what gets publicly reported gets improved in the health care world. [1] For the past five years, we also have waged an intensive, multi-year, national campaign-- with a strong California component-- to stop hospital infections and promote patient safety. See www.stophospitalinfections.org.

We are pleased that the Administration adopted the recommendation of the Commission to create a new, separate Department of Public Health. The Commission's ongoing efforts to study the state's capacity to face the challenges posed by bioterrorism and infectious disease has already resulted in this positive improvement. Consumers Union is hopeful that the dedication of public health functions in a separate department will provide the needed focus, resources, and action-oriented attitude warranted by the scope and importance of the public health risks we face, including from medical errors and hospital-acquired infections. We have seen positive signs of this in the Department's implementation of the new medical errors reporting and public disclosure requirements under SB 1301.

Background on Hospital-acquired Infections Policy in California

Regrettably, we do not yet see the same headway on hospital-acquired infections (HAIs). As the Commission has previously stated, "…it is conservative to estimate that more than **10,000 Californians die annually** from this cause." Little Hoover Commission, Emergency Preparedness Report, June 23, 2005, footnote 12, pp. 13-14. In that report, the Commission called upon the Governor and Legislature to:

[1] See, e.g., "Hospital Performance Reports: Impact on Quality, Market-Share and Regulation", Hibbard, J., Stockard, J., and Tusler, M., Health Affairs (July/August 2005)

> Develop an aggressive response to hospital-acquired infections. By December [2005], the administration should propose a plan…that will reduce the illness and death resulting from these infections.

According to the Administration, in addition to these unnecessary deaths and countless serious injuries, HAIs add **$3.1 billion in health system costs** each year in California. And with a developing body of research on antibiotic-resistant "superbugs" such as MRSA showing that heretofore under-estimated problem growing, the cost in live sand dollars is likely even greater[2]. Further, other dangerous superbugs, like Clostridium difficile are on the rise. The Agency for Healthcare Research and Quality issued a report this year stating that the number of hospital patients with infections caused by this bug more than doubled from 2001-2005.[3] California must put the hospital infections issue on a fast track.

While California historically has led the nation in so many consumer protection areas, unfortunately we are far behind the rest of the nation in informing its residents about the risk of hospital-acquired infections. Public disclosure by facility of infection rates is the only way we can begin to understand the scope of the problem and which hospitals are taking this problem seriously, as well as to spur improvement. Unfortunately, our state has taken the slow route, with much resistance along the way by the California Hospital Association and large hospital systems.

In 2004 Senator Jackie Speier introduced SB 1487, a bill which would have put CA at the forefront of states by requiring hospitals to report infection rates publicly via the Department of Health Services. That bill was vetoed by Gov. Schwarzenegger in Sept. 2004. The reasons cited were that the law was not needed due to various private initiatives in effect (such as JCAHO and the National Quality Forum – neither of which collect infection information), the cost to hospitals was too high, and auditing was not provided for in the bill.

In Feb. 2005, Senator Speier introduced SB 739, to require reporting of infection rates. In July 2005, the Department of Health Services convened an advisory working group to look into hospital-acquired infections. As the group's final report stated, the group "could not achieve consensus on a recommendation regarding public reporting of health care-associated infection rates or mortality." Overwhelmingly dominated by hospitals and the health care industry, the working group contained just 2 consumer representatives out of 31 members.[4]

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[2] A 2007 national prevalence study by the Association for Professionals in Infection Control (APIC) found MRSA to be 8-11 times more prevalent than prior estimates and that most of these infections were acquired in a hospital or health care setting. "National prevalence of methicillin-resistant Staphylococcus aureus in inpatients at U.S. health care facilities, 2006"; William R. Jarvis, MD, JoAnn Schlosser, MA, Raymond Y. Chinn, MD, Samantha Tweeten, MPH, PhD, and Marguerite Jackson, PhD, RN; American Journal of Infection control, Vol 35, No 10.

[3] "Clostridium Difficile-Associated Disease in US Hospitals, 1993-2005," Heathcare Cost and Utilization Project, Agency for Health care Research and Quality, April 2008.

It should be no surprise, therefore, that its final report, rejected public reporting asserting "insufficient evidence regarding the effectiveness of public reporting systems." This finding was used as fodder against public disclosure of infection rates proposed in the original draft of SB 739. Senator Speier agreed to a compromise so the bill would move forward—unfortunately, the compromise did little to ensure the safety of the state's hospitals. In 2006, the year California failed to pass a bill to publicly report infection rates by hospital, 15 other states required these outcome measures.

The version of SB 739 that became law requires:

- Appointment of a stakeholders' advisory committee, including "**health care consumers**";
- Hospital reporting of HAI surveillance and infection prevention **process measures** (several already reported to CMS, the federal agency, by almost all hospitals that do business with Medicare) by Jan. 1, 2008;
- **Public reporting of those process measures** within 6 months of receipt by the Dept.;
- **Recommendations by Jan. 1, 2008 by the Advisory Committee for phasing in public reporting** of additional process measures and outcome measures, i.e. infection incidences;
- Hospitals offering on-site, **no-cost flu vaccinations for all employees**.

In 2008, two excellent bills were introduced and are pending in the Legislature aimed at improving public disclosure and prevention of HAIs. **SB 1058** by Senator Elaine Alquist requires reporting of hospital infection rates related to surgery and central line associated bloodstream infections; screening of selected patients fro MRSA to prevent its spread; and hospital reporting of infections caused by MRSA, c. difficile, and VRE—all superbugs that are difficult to treat. **SB 158** by Senator and Commission Member Dean Florez requires hospital personnel, including doctors, to receive training in infection control; hospitals to establish patient safety committees to develop patient safety plans and hand hygiene campaigns; and strengthened responsibilities of the state HAI Advisory Committee.

Implementation of SB 739

The Advisory Committee was assembled in 2007, and Consumers Union nominated for membership an activist who has worked extensively with our campaign, Carole Moss. Ms. Moss' 15-year old son Nile fell victim to a MRSA infection during a brief hospital stay for tests, and died as a result. Ms. Moss was appointed to the Advisory Committee and brings her informed experience to bear. Still, she has confronted numerous impediments to making successful changes regarding HAIs in California.

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[4] Lisa McGiffert for Consumers Union and Beth Capell for SEIU were the two consumer representatives. Ms. McGiffert, located in CU's Texas Office, participated by telephone. Thirteen individual hospitals' representatives, a Vice President for the California Hospital Association, and a representative for health facilities were the predominant other members. Miscellaneous other interests included a representative of the California Medical Association, one for the California Nurses Association, and various government agencies.

These are some of the issues she has confronted, and Consumers Union has observed in the operation of the Advisory Committee and implementation of SB 739:

- Ms. Moss is the sole consumer representative—1 out of 37 members. The statute provides for "health care consumers", yet there is just one.
- While the Committee aims to operate by consensus, many of the issues it deals with—especially public disclosure of infection rates—are highly contentious with hospitals. When consensus is not achievable, a 2/3 vote decides the Committee's position. With a 37-1 composition, Ms. Moss most often finds herself a perpetual minority vote.
- As of July 31, 2008, according to the DPH, only 65% of hospitals are enrolled in the CDC National Healthcare Safety Network (NHSN), the entity the Committee recommended to use for collecting data on, for example, flu vaccinations. We believe this is the percentage reporting their measures already to CMS, the federal agency;
- The surgical infection prevention measures required to be reported under this law by July 2008 have yet to appear on the state's web site. This information is already collected via CMS' "Hospital Compare" initiative. According to DPH, California's QIO (Lumetra) is helping hospitals not already reporting, but the state should be posting the information currently available via CMS on the state web site to be in compliance with SB 739. We find no public reporting on these hospitals' compliance on the DPH web site, nor links to the CMS site, although the public reporting is required by July 2008. The state could also get the data from CMS and provide enhanced information to the public.
    - As of June 2006 (federal FY2007) the annual Medicare payment update to hospitals is reduced by 2% for any qualifying hospital that fails to submit two of the surgical infection measures (timing of antibiotics 60-minutes before and discontinue 24 hours after surgery). Numerous hospitals are exempted from this payment system and thus are not required to report. These are typically small rural hospitals ("critical access hospitals") that probably do little or no surgery.
    - According to CMS, 284 California hospitals qualified for the full payment for FY2008 (as of Feb. 2008) and 41 did not qualify for the full payment (i.e., did not report full data) – we cannot tell which data was not fully reported. One chose not to participate.
- In fact, DPH has repeatedly missed its deadlines under the statute. For example, the Advisory Committee was charged with making recommendations by Jan. 1, 2008 for phasing in public reporting of additional process measures and outcome measures, i.e. infection incidences. We understand that several months ago the Committee recommended that MRSA blood stream infections be publicly reported, yet we find nothing on the DPH web site to indicate that has happened.
- There is no public reporting of whether hospitals offered the statutorily required on-site, no-cost flu vaccinations for all employees, nor of the take-up and declination rates. Our understanding is that this measure is to be reported via NHSN, in which all hospitals have yet to enroll. DPH simply states that hospitals must improve their documentation from what was reported in 2007-08, and that it "continues to work closely with hospitals on improving health worker vaccination rates."
- The DPH philosophy regarding SB 739 emphasizes helping hospitals over aggressively protecting and improving patient safety.

- The Advisory Committee operates without any funding currently. Thus, when Ms. Moss travels to attend the Committee meetings, she does so using her own funds and is not reimbursed. In addition, the Committee's staffing has suffered because no funds were approved for SB 739 implementation.

National Context on HAIs

Today, 24 states have laws requiring disclosure of hospitals infection rates: CO, CT, DE, FL, IL, MA, MD, MN, MO, NJ, NY, NH, OH, OK, OR, PA, RI, SC, TN, TX, VA, VT, WA, WVA. For summary of state laws, see "State Hospital Infection Disclosure Laws" at http://www.stophospitalinfections.org/learn.html. Some states require other facilities to report infections, such as ambulatory surgical centers and nursing homes. Most of the states have started using or have decided to use the CDC National Healthcare Safety Network as the tool for gathering and analyzing infection data. The data is then provided to each state's agency responsible for public reporting.

Three states require MRSA screening for selected hospital patients (IL, PA, NJ). For a summary of these laws, see "State MRSA laws" at http://www.stophospitalinfections.org/mrsa.html .

Seven states that have issued reports: FL, PA, MO, VT, SC, CO, NY (aggregate only in the first year). Links to these reports can be found at http://www.stophospitalinfections.org/learn.html.

Several Congressional bills have been filed that would require a national reporting law as well as provisions aimed to prevent the spread of MRSA – one includes screening hospital patients for MRSA (all incoming patients by 2012). There has been no significant activity on these bills so far. See "Congressional Legislation" at http://www.stophospitalinfections.org/learn.html to view information about these bills.

Other issues beyond reporting infection rates have emerged. They include:

- **Using active surveillance cultures to screen incoming hospital patients for MRSA**. Many hospitals also are using this to screen patients having scheduled surgery; if a surgery patient tests positive for MRSA colonization, steps are taken to de-colonize the patient before the operation and to use prophylactic antibiotics that are effective against MRSA.
- **Reporting MRSA, c. difficile, and VRE infections** (currently addressed in pending bill SB1058). These three virulent superbugs have garnered much attention over the past few years as they have become more and more prevalent in our nation's hospitals and health care facilities.
- **Medicare non-payment of certain hospital-acquired conditions.** CMS was directed by Congress to select at least two conditions. On October 1, 2008, Medicare will no longer pay for the additional costs of 11 hospital-acquired conditions, several of which are related to hospital-acquired infections. A number of states have initiated similar policies for Medicaid and other state insurance coverage. Several insurers have announced similar policies and the American Hospital Association and many state hospital associations have called on hospitals to stop billing for these "never events." Most of these state and insurer

no-payment policies do not include hospital-acquired infections, which represent the highest costs among the conditions. These efforts to link payment to harm done to patients aim to motivate hospitals to institute more aggressive prevention techniques.

Conclusion and Recommendations

The Department of Public Health needs to reflect greater urgency in addressing the deadly and expensive public health problem of hospital-acquired infections. Having a majority of members on the Advisory Committee from the health care industry creates a natural drag on the process since they have disincentives to getting the work done, particularly as it relates to public reporting of outcome measures. While most states are taking up to two years to implement reporting systems, those with disclosure laws are all reporting infection rates, which is a more complex measurement than simply reporting infection incidences or process measures.

To date, the SB 739 Advisory Committee only has had to report on very limited process measures, some of which most hospitals were already reporting to another entity (CMS). Yet no data is available to the public. There is no excuse for taking this long. The cost of hospital-acquired infections in lives and dollars is too great to allow for delays. We need a commitment from the Department to move forward aggressively to address this deadly problem.

A few specific recommendations:

A. Committee Membership: A majority of public members, avoiding "insider" industry members, and prohibiting hospital and health care industry lobbyists, would be preferable to the current composition of the Advisory Committee. Having just one consumer representative ensures that patient voices will be excluded from the process. We also suggest:

- Full, public disclosure of financial and other interests of all advisory committee members. Sunshine will foster public confidence and the very fact of required disclosure may weed out biased nominees or at least document the need for recusal. Many of the members of the SB 739 Committee, we understand, are lobbyists paid for by hospitals.
- Training all board members on their public role as advisors.
- Dissenting, minority opinions be committed to writing and made part of the public record.

B. Public Participation: With the limited consumer representation, the Committee should extend itself to foster and facilitate public input and seek that perspective through public comments. When the consumer representative initially requested to start each meeting with a different patient's statement, the Advisory Committee returned with a list of limitations regarding what the person could say. In the end, these patient statements were allowed, but not without "chilling effect." The committee now allows people to attend these meetings via teleconferencing, which has enhanced the ability for the public and Advisory Committee members to more fully participate.

C. Staffing and Resources: Appropriations for SB 739 implementation and the Advisory Committee work have been an issue, as described above. We strongly support the provision in SB1058 that brings this work under the licensing division, thus allowing for fees on hospitals to

support implementing a public reporting system. Along with funding, solid staffing for the Advisory Committee process is essential. These staff should have substantive knowledge and the ability to move the process along if it is falling behind on deadlines. The staff and department should be proactive in informing the public when information becomes available. The DPH web site is a beginning, but as noted above key data and links are missing.